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ABSTRACT

This book chapter describes the 14-year evolution of Community Behavioral Services, a provincial government-operated program in Edmonton, Alberta. The program began in 1976 as a residential treatment facility for individuals having mental retardation and severely challenging behaviors. Later, a specialized family home was established as a halfway house between the residential program and family placement. Still later, these residential facilities were replaced by alternative programs which provided relief, consultation, and intensive support as well as workshops and seminars to parents and community agencies. The paper describes several problems associated with residential programs, processes involved in planning the transition from residential to outreach services, and evaluation procedures and instruments used to ensure effective service delivery. (JDD)

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Chapter 7
Behavioral Support: A Transition from Residential to Outreach Services

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This chapter describes the 14-year evolution of Community Behavioral Services, a program in Edmonton, operated by the Alberta Provincial Government. The program began in 1976 as a residential treatment facility for individuals having mental retardation and severely challenging behaviors. Later, a specialized family home was established as a halfway house between the residential program and family placement. Still later, these residential facilities were replaced by alternative programs which provided relief, consultation, intensive support, as well as workshops and seminars to parents and to other community agencies. The authors describe several problems associated with residential programs and a number of useful evaluation procedures and instruments to ensure effective service delivery.

The mid-1970s, at least in Alberta, can be viewed as a turning point in the development of services for people with mental disabilities. In those days, they weren't called "people with mental disabilities," they were called "retarded." And individuals with challenging behaviors were known as "behavior problems." Many such people lived in large, segregated institutions. In Alberta, for example, Michener Centre accommodated over 2,500 people who, for various reasons, were considered to be unable to live in their communities.

Professionals had been advising parents for several decades that the institution was the best place for their retarded son or daughter. Why? Because it was the *only* place. Very few services existed to help parents cope with the additional stresses of raising a child having intellectual retardation.

In the mid-1970s, things began to change. In response to a number of factors, such as parent advocacy, normalization principles, progressive legislation, and economic prosperity, increasing efforts were made to develop a range of community services. "Deinstitutionalization" became the rallying cry in the human services field. Some, but not all, people began returning to their communities, opting for smaller, residential settings such as group homes, foster homes, and living with their natural parents.

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Michener Centre reduced its population by nearly 1,000 within the ensuing 15 years. Hopefully, this trend will continue into the 1990s with more and more options being made available for people who choose to remain at home and be a part of community life.

The purpose of this paper is to describe a program for children with mental disabilities and challenging behaviors. The name of the program is Community Behavioral Services, operated in Edmonton by the Alberta Provincial Government. The discussion reviews the program in its early days and describes how it changed in response to changing community needs. The information will be helpful to others who provide community-based services for similar children.

In 1974, a group of parents approached the government saying, "We can't keep our kids at home any more, and we don't want to send them to the institution." These children all had challenging behaviors; they were aggressive, destructive, noncompliant, self-abusive, and so forth. They were the type of children that would put a strain on any caregiver and, as a result, they were often barred from participating in community programs. In those days, school teachers could tell parents to take their kids home; "He is just too disruptive to the rest of the class." Of course, expelling children from school only placed additional stress on parents who then had the problem of deciding what to do with the children at home.

To address these concerns, representatives from the newly formed Services for the Handicapped program of the Alberta Government asked these parents what services they needed. What came out of these discussions, at least for Edmonton, was a behavioral support service which included a six-bed, short-term residence and a small outreach team: Community Behavioral Services.

The Residence

By 1976, the residential program began to accept children with mental handicaps who displayed severely challenging behaviors. A renovated duplex, with six bedrooms, was used to provide short-term residential accommodation for the assessment and training of five children. The sixth space was available to children for periods up to 30 days to provide relief to parents.

Within the residence, a team of nine counsellors (Rehabilitation Practitioner I's) were involved in the design and implementation of individual learning programs, based on an assessment of each youngster's behavioral excesses, deficits, and assets. Parents were expected to remain involved with their children by visiting the residence at least once a week to help develop and carry out the behavior change programs under staff guidance. To ensure that parents developed behavior change skills, four counselors in the Outreach Program provided short-term behavioral workshops, supplemented with weekly home consultation visits. The intent of this training was to facilitate the reintegration of children into their natural homes.

On average, children stayed in the residence six to eight months before returning home. Follow-up services by outreach staff continued for at least three months, or longer if necessary, to ensure parents were capable of maintaining and teaching appropriate behaviors.

Unfortunately, some children were unable to return to their natural parents, for a variety of reasons, and attempts were made to place them in foster care. However, access to foster care homes was frequently unavailable because children from the Community Behavioral Services residence were labeled "behavior problems." Social workers responsible for placing children with foster care families often argued that although a particular child may have behaved appropriately in the residence with strict guidelines and a large staffing component, she/he would probably not behave similarly in a family-type setting.

Specialized Family Home

To counteract this argument, a halfway house was established in 1978 called the Specialized Family Home. This three-bedroom home was to be used as a stepping-stone to the community; that is, the structured behavioral programs established in the residence were to be gradually phased out within a family-like environment, thus providing children with an opportunity to prove that they could function in a less restrictive setting. The home was permanently staffed by a couple who were provided with consultation support through the Outreach Program.

Many positive changes were made over the six years that the Specialized Family Home was in operation. Higher qualifications of "parents" were required, a full-time in-home specialist was hired to provide more support, admission criteria were strengthened to ensure post-placement was available, parents were given more responsibility and independence in the operation of the home, and benefits and salaries were increased substantially.

In spite of these changes, it was difficult to maintain a continuous operation from year to year. While nine children made use of the home, four different pairs of houseparents came and went. It became increasingly obvious that the job of parenting three children with challenging behaviors was not an easy one, even with the support of an in-home specialist. The job was both technically demanding and emotionally draining. Several times, when house parents terminated, children had to be returned to the residence which itself was usually operating at full capacity. After six years of never quite meeting expectations, the Specialized Family Home was closed.

Downsizing

In 1984, the year the Specialized Family Home closed, government implemented fiscal restraint measures and encouraged innovative ideas to "do more with less." After a thorough review of program and budget issues, it

was decided to close the six-bed residence, relocate to a three-bed residence, and use the Specialized Family Home facility for a second three-bed residence. Both facilities had two permanent beds and one relief bed. The smaller residential units, in comparison to the six-bed residence, were expected to provide more individualized attention to each child, more consistency in programming, less negative modeling, and a more normalized environment which would reduce reintegration difficulties when a child returned home.

Our experience with the Specialized Family Home suggested that a permanent live-in operator supported by sufficient staff would provide the necessary consistency in programming, while at the same time minimize burnout of the operator. The contracted operator, supported by four counselors in each home, participated as a team member and was also responsible for household maintenance.

In the first year of operation, several individuals and couples came and went as operators in each of the homes. It was difficult to find someone who was willing to remain in the job for an extended period of time. In some cases, operators who left reported that they had been "happy" with the job; in other cases, they said they couldn't tolerate the stress associated with continuous exposure to children with severe behavior problems—they left with a career change in mind.

In 1985, continued fiscal restraint and the department's emphasis on downsizing resulted in a decrease of four positions at Community Behavioral Services, requiring the closure of one of the children's residences. The remaining residence would provide two permanent spaces and one relief space to serve the Edmonton region. Considering that the waiting list for the residential program averaged five to six children, a change was made to the service process. Instead of serving children until they met predetermined behavior change criteria, a child would stay for a maximum of 12 weeks, during which time both the child and the parents received instruction to increase the likelihood of success when the child returned home.

Problems with the Residential Program

The major concern throughout the 11 years of operation of the children's residential program was the unavailability of post-placements, resulting in a lack of movement from the residence. Although admissions required a post-placement, such placements were not always available when a child was ready for discharge. This situation was not only detrimental to the child who should have been moving to a less restrictive setting, but it also prevented other children from accessing the program.

A problem related to the lack of post-placements was the decrease in parental involvement once children were placed in the residence. Although attempts were made to contract with parents to stay involved on a regular basis, the contract provided very little leverage once the govern-

ment assumed responsibility for a child's placement and treatment.

Another problem related to congregating individuals with behavior problems in one facility was the lack of positive role models. Children often imitated the negative behaviors displayed by other residents, resulting in prolonged involvement while staff attempted to cope with the "new" behaviors.

A final problem was the difficulty of achieving generalization of children's appropriate behaviors from the residential setting to the parental home. The consistency and intensity of programming provided in the residence did not occur in the home settings. Thus, long-term maintenance of behavior change was often not achieved.

Survey of Needs

In 1986, because of the problems encountered in serving children in the residential program, it was decided to conduct a survey of community needs related to serving children with challenging behaviors. Two separate survey forms were developed: one for families, and one for community agencies. Survey questions focused on the types of service options both families and agencies could possibly use. Families were asked about the need for relief, short-term residential training, and in-home intensive support. Additional information was obtained from the parents regarding their perceptions of the level of their child's inappropriate behaviors (mild, moderate, or severe).

Agencies were asked what additional supports they required to accommodate children with challenging behaviors. The range of possible supports included formal training of staff, additional staffing, consultation, hands-on support, and so forth. Information was also obtained about the number of children with behavior problems, education of staff, and staff training needs.

Survey forms were sent to 236 families and 28 children's agencies in the Edmonton region.[1] Completed forms were returned from 49 families (21%) and 21 agencies (75%). The results of the parent survey are described below.

Parents were asked to rank order their service preferences from 1 to 5, with 1 being "most useful" and 5 being "least useful." The average rank order of responses indicated the usefulness of the service options; the closer the rating was to 1, the more useful that service was to the family.

Out-of-home relief, on a periodic basis, was considered to be the most useful service (ranked 1.3) with short-term residential placement being the least useful (ranked 2.3). Intensive support received an intermediate ranking (2.1). While 29 families rated relief as the most useful service (ranking = 1), only four families rated short-term residential training as their most useful service. It is interesting to note that those parents who categorized their children as having mild or moderate behavior problems tended to choose relief or intensive support as their most useful service. The parents who

considered their children to have severe behavior problems tended to choose short-term residential training as their most useful service.

In the children's agency survey, modeling of behavioral techniques was considered to be the most useful service that could be provided to them (ranked 2.3); hands-on program implementation was considered to be the least useful service (ranked 3.5). Consultation on behavioral techniques, observing and providing feedback to staff, and formal inservice training were at intermediate levels of usefulness for staff in children's agencies (ranked 2.5, 2.9, and 3.2 respectively). Most agencies indicated that over half of their staff (a total of 356) would benefit from additional training in behavioral program design. In fact, only two agencies indicated that such a service would not be beneficial to them at the time of the survey.

Several conclusions were drawn from the survey feedback:

(a) Parents expressed a strong need for out-of-home relief and intensive, hands-on support.
(b) Children's agency staff identified modeling techniques and training in behavioral-program design to help them deal more effectively with challenging behaviors.
(c) Very few children required out-of-home placement in a specialized treatment facility.

In summary, the survey results suggested that both parents and agency staff would be able to maintain children in their existing placements if they had more access to relief, intensive support, and formal training in behavior change strategies.

Planning the Transition

On the basis of these identified community needs, Community Behavioral Services began planning for a major shift in service delivery. Whenever possible, families and agencies were to be supported in their efforts to maintain children with maladaptive behaviors rather than moving them to specialized residential facilities. For children requiring highly structured management programs within a facility-based environment, it was proposed that they not be congregated in a specialized facility, but rather that they be dispersed among the existing residential services in the Edmonton region and that they be moved to less restrictive settings as their behaviors improved. By bringing behavioral supports to the home or agency, a specialized residential program would be unnecessary.

To ensure a smooth transition from residential to outreach services, Community Behavioral Services staff developed a communication plan that identified objectives and strategies for all stakeholders. The following examples illustrate a few particulars of the plan.

For parents

Objective: To ensure that no gaps in relief service occurred during the transition period.

Strategy: Develop alternate relief services by contracting with host families.

For children's agency staff

Objective: To promote interest in and commitment to the new outreach services.

Strategy: Conduct a survey to solicit agency input into the parameters of the new outreach services.

For Community Behavioral Services staff

Objective: To ensure residential staff are aware of and support the proposed changes.

Strategy: Update staff regularly and solicit their input into action plans, as appropriate.

For the public

Objective: To inform potential consumers and relevant interest groups of the proposed changes.

Strategy: Prepare media items for agency and association newsletters.

For government support services

Objective: To inform Personnel/Payroll of changes in position descriptions and classifications.

Strategy: Reclassify residential staff to higher- level, outreach positions.

For Public Works

Objective: To ensure staff have a suitable working environment.

Strategy: Arrange for Alberta Public Works to renovate the children's residence into offices for outreach staff.

For a six-month period in 1987, Community Behavioral Services continued extensive contact with parents and children's agencies, while providing appropriate training opportunities for internal staff to facilitate the transition from residential to outreach services.[2]

Closing the Residence

In 1987, the last child was discharged from the residence and the doors were closed to any new admissions. During the 11 years of operation, the Children's Residential Program provided short-term treatment to 68 children and relief accommodation to 553 children.

The "success" rate, defined as meeting a predetermined level of behavior change or parental satisfaction with the amount of change achieved, was about 75%. Only a few children were unable to remain at home following discharge from the residential program. These children were usual-

ly accommodated successfully in other agencies' facilities, often with support of the outreach counselors.

Outreach Model

From the needs survey described above, it was apparent that families wanted occasional out-of-home relief and intensive, hands-on support, defined as one-on-one programming. Staff from children's agencies wanted formal training in behavioral techniques and the modeling of these techniques with individuals they served. On the basis of this information, we developed three separate but interrelated services (relief, training, and intensive support) to replace the residential program.

Relief. Although a number of agencies provided out-of-home relief to parents of children with mental disabilities, none would accept children with "severe" behavior problems, for example, those requiring extensive supervision because of self-abuse, aggression, running away, and so forth. In the past, such children were accommodated in the relief bed(s), about 50 each year. Closing the residence meant that relief had to be provided elsewhere for those children.

In the needs survey, 90% of the parents indicated that out-of-home relief would be useful, mostly on weekends and during holiday periods, and preferably in a family-like atmosphere. Thus Community Behavioral Services advertised for several host families willing to provide occasional relief to parents by accepting a challenging child into their home. These host families would have to have at least one year of rehabilitation training, and experience in working with mentally disabled children. They would be well paid and supported by an aide and behavioral counselor, as required. A half-time relief coordinator would be hired to recruit host families, review referrals, and arrange relief.

Training. When staff in children's agencies were asked in the needs survey whether training in behavioral program design would be a useful service, almost all agencies indicated that it would be. To provide this training, a specialized training program was established to offer a variety of training options. These training options are described below.

(a) *Parent workshops*

Community Behavioral Services had been offering parent training through its Outreach Program for the last 10 years. Its purpose was to help parents develop skills for dealing more effectively with the behavior problems of their children. These behavior change skills were taught in a workshop format several times a year. A group of parents met one evening a week for four to six weeks. During these meetings, parents were instructed in behavior change principles and procedures, utilizing a teaching package developed by Community Behavioral Services. The sessions were made as interesting as possible by incorporating films, videotapes, demonstrations, and parents' own experiences.

During the course, a behavioral counselor from Community Behavioral Services visited each parent weekly. These home visits provided parents with the assistance and support necessary to carry out a behavior change program with their children. Subsequent to the workshop, a three-month follow-up was provided to assist with any difficulties that arose. This follow-up was extended if desired by the parents.

(b) *Agency workshops*

To address formal staff training in a variety of children's agencies, it was decided to offer behavioral workshops similar to those that had been provided to parents. Involvement began with a brief assessment of staff needs, followed by a period of observation and collaboration in order to tailor the workshops according to these needs. The delivery of information ranged from half-day sessions to many hours over a period of months.

During these sessions, staff were instructed in behavior change principles and procedures. Time was set aside for problem solving and considerable emphasis was given to the topics of generalization and maintenance. Staff were expected to apply the procedures learned in the workshops to effect behavior change in the individuals they served.

(c) *Seminars*

In some cases, agency staff or parents may simply have a presentation on a particular topic such as normalization or "positive approaches" to behavior management. It was decided to offer these presentations in the form of single-session seminars. These seminars differed from the workshops in that they did not necessarily involve the establishment of behavior change programs by participants.

(d) *Personal development workshops*

Over the years, it became obvious that a number of teenagers and young adults required information or instruction in the area of sexuality and interpersonal relationships. To meet this need, a workshop was provided where these individuals could meet with a group of peers to discuss a variety of related topics. These groups usually met two evenings a week for six to eight weeks; a flexible curriculum allowed for addressing individual needs.

Intensive support. The needs survey indicated that both families and agencies could benefit from a form of on-site intensive support that included modeling of behavioral techniques and one-on-one programming by Community Behavioral Services staff. Up to this point, outreach services consisted of weekly visits to families and agencies for an hour or so to give advice on program design and implementation. Although this consultative approach was useful to the recipients in some cases, it was obviously not enough. Many parents and agency staff were unable to implement the suggestions of the counselors.

What was needed was a separate program for families and agencies requiring more assistance than consultation alone could provide. Assistance would involve hands-on support in both homes and agencies. The counselors would model the appropriate use of behavioral techniques, provide suggestions, and work closely with families or agency staff in program design and implementation. Termination would occur when parents or agency staff acquired the necessary skills to ensure a child could be maintained in that setting. In most cases, this would involve an agreed-upon level of improvement in a child's behaviors. Following termination, the counselor would maintain regular contact for up to a year, with regular phone calls and periodic visits.

Evaluation

During the first year of providing these new services—relief, training, and intensive support—information was obtained from parents and staff about their levels of satisfaction with the services and the degree of behavior change that occurred as a result of the additional support. Overall, the results were very encouraging.

Relief. Host family relief beds were used by 69 children during the year (over 80% of the time that they were available). Responses on a Satisfaction Survey indicated that parents were "very satisfied" with the ability and willingness of host families to serve their children. Many parents reported that the availability of such relief services greatly reduced the need for specialized placement outside the home. In fact, Community Behavioral Services has yet to encounter a child who cannot be accommodated with a host family, given the option of additional support of an in-home aide and consultation from the Intensive Support Program.

Just recently, Community Behavioral Services contracted with a transitional host family for placement of children who could not remain at home for various reasons. The purpose of these placements, for up to six months, was to allow a service plan to be developed that considered the needs of a child for alternate placement, perhaps with a foster family. Currently, it is too early to evaluate the success of this new service.

Training. Formal behavioral workshops were provided to 27 families and one agency during the year. Twenty-two seminars were provided to various agencies and one personal development workshop was provided to six adolescents. In all cases, parents and staff indicated a high level of satisfaction with these services.

Intensive support. Intensive, hands-on support was provided to 29 families and 13 children's agencies, resulting in 43 children being served. Once again, parents and agency staff indicated a high level of satisfaction with this service. In a sample of 21 of these children, 19 (90%) showed a positive behavior change. Only two children showed no improvement but continued to reside with the family requesting service.

In the previous residential program, about five children were served each year. With the same number of staff, intensive, hands-on support was provided to nearly eight times as many children in both home and agency settings. This increase in service delivery translates into a per-diem cost reduction from $116.00 for the Residential Program to $15.00 for the Intensive Support Program.

Current Service Process

The remainder of the discussion, describes a new service process and a few of the formal mechanisms (highlighted) used to ensure appropriate and effective services are delivered.

Referrals to Community Behavioral Services come first to the social worker who conducts an interview, gathering relevant information for the Referral Review Committee. The social worker leaves reading material with the parents or agency staff that describes the programs at Community Behavioral Services, other useful resources (e.g., listed in a specially prepared *Resource Manual*), and what to do until service can be provided. This *While You're Waiting* pamphlet provides some helpful hints on managing disruptive behaviors.

A *Priority Scale* was developed to help assess children according to their need for service. This scale takes into consideration the extent to which home or school placement is in jeopardy, the general attitude of parents or agency staff toward the child, and their willingness to be involved in programming. Use of the scale provides more objective decisions as to which referrals are most in need of service and which Community Behavioral Services program(s) would be most appropriate.

Upon determining the service needs, Community Behavioral Services staff and the parents or agency staff enter into an a *Service Agreement* outlining the terms of service, including the responsibilities and expectations of both parties. Parents or staff are informed of the general approach to be used in training, the nature of the service (consultation or intensive support), and the appeal route to be used in the event that they are dissatisfied with the service. Community Behavioral Services agrees to provide the appropriate service and each service recipient agrees to participate, for example, by attending the workshops and carrying out behavior change programs.

Front-line involvement begins with several visits to the child's home for the purpose of completing a comprehensive *Observation and Assessment*. These initial contacts provide the opportunity to develop a positive consultative relationship, as well as to gather information on various aspects of the child and his or her environment. Observations are made of interactions of the child with various family or staff members, the type and quality of communication, day-to-day routines, the range of activities, behavioral strengths and weaknesses, and so forth. This assessment is usually completed over several weeks and results in recommendations that direct

the delivery of services. Through a collaborative effort, behaviors are operationally defined and a base-line is taken to determine preintervention levels.

As part of this program planning phase, a *Motivational Assessment Scale*[3] is also completed. The purpose of this scale is to identify the variables involved in maintaining the inappropriate behavior (for example, head-banging may be maintained by its sensory consequences).

Prior to the development of a behavior change program, a literature review is conducted to assist in determining effective ways of dealing with the chosen target behaviors. A *Continuum of Procedures*[4] is referenced to ensure ethical interventions proceed from least to most restrictive.

Once a behavioral program is designed and ready for implementation, the counselor teaches the program to all mediators involved with the child. This teaching includes hands-on implementation by the counselor and observation and feedback to mediators until they are able to run the program independently.

A *Program Checklist* has been developed that counselors use as a guideline to identify possible areas of difficulty when programs are not working. This checklist includes questions on such areas as mediator consistency, use of effective reinforcers, completion of various assessments, possible training requirements, and so forth.

It does happen, in spite of using the checklist, that some programs do not work as planned. In such cases, a peer review committee meets to discuss factors relating to the lack of progress. This internal committee includes the program manager, psychologist, supervisors, and the counselor. A *Peer Review Checklist* is used to assist the committee in evaluating the services provided to date. The checklist includes a variety of questions pertaining to: length of baseline, mediator skill level, consistency, and so forth. Peer reviews generally result in brainstorming for solutions with recommendations to be used by the counselor. Once consultation or intensive support staff have accomplished their objectives, they begin to fade involvement. One of the last things the counselor does is to review thoroughly a *Trouble Shooting Guide* with the mediator. This guide is intended to help the mediator evaluate and modify the child's behavioral program if things are not going as expected. The guide also helps to reduce the dependency that many mediators develop through the course of consultation from Community Behavioral Services.

To get feedback as to the mediator's satisfaction with the counselor's involvement, they are asked to complete a *Service Evaluation* and forward it to the Program Manager. The information from these evaluations is used to make improvements in areas specific to the service process.

A month after the file is closed, the Program Supervisor arranges a visit with the mediator and completes a *Supervisor's Interview Questionnaire* that addresses topics specific to the counselor. Such things as the counselor's attitude, flexibility, intrusiveness, and training he or she provided are

reviewed. This information is then used for performance feedback to the counselor and for making changes to the service process.

Follow-up phone calls by the counselor at three, six- and 12-month intervals complete Community Behavioral Services' involvement. After 12 months a *Follow-up Questionnaire* is used by the counselor to determine the need for reinvolvement.

Notes

1. An additional survey form was distributed to those agencies serving adults; however, a discussion of those results is beyond the scope of this paper.
2. In the previous year, we had undertaken a similar exercise in converting an adult residential program to outreach. A review of that exercise helped to smooth the transition of the children's services.
3. Additional information and copies of the Motivational Assessment Scale are available from William V. Mark Durand, Department of Psychology, State University of New York at Albany, 1400 Washington Avenue, Albany, New York 12222.
4. For a detailed description see Brazier, B. and MacDonald, L. Ethical decision-making in behavioral programming: A continuum of procedures. *Journal of Practical Approaches to Developmental Handicap*, 1981, *4*(3), 11-13.